GETTING MOTIVATED

Has your 'get up and go' got up and gone?

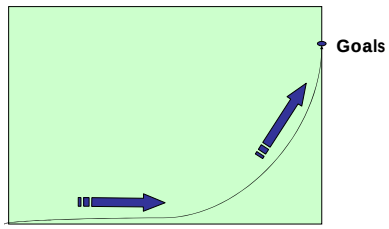
Problems to do with stress and mental health problems can seriously affect what we do and how we do it. All areas of life can be influenced—work and study can be difficult to pursue when you feel distracted, have poor concentration, lack the will to do things or just feel completely exhausted.

While this happens to everybody at some time in their life, when it becomes a persistent problem going on for weeks or months, simply hoping it will get better isn't good enough.

Relationships can be affected because you don't feel like talking or just can't seem to get the words out. It may be difficult to feel close to others when you're distressed or just numbed.

Interests in hobbies, sports, TV, music, going out, friends and other people may be affected and lead to a decrease in activities This can mean getting increasingly isolated and even if you used to be reasonably sociable , you can get quite cut off and become socially withdrawn.

Achieving expectations



You can't push yourself - or anyone else - out of 'negative symptoms'

But there is a lot you can patiently do

Sometimes this can make life feel easier - less stressful – but in the long term can become dull, boring and depressing.

These symptoms are sometimes called 'negative' symptoms (see over page) and can be very disabling. It is very important initially to reduce feelings of stress and then start to set goals which are well within your capacity to do, with your mental health worker.

Setting reasonable goals

How much time do you need to rest and recover?.....months/years

Once feeling more relaxed, what would be your first step to getting back to 'normal'?

……
……(Don't complete until you feel ready to do so).

What are your longer-term goals, in 5-10 years time?

Work/study……

Relationships……

Hobbies/leisure……

Living arrangements……

What are negative symptoms?

The term 'negative' symptoms is used to describe a set of problems which are quite disabling and often difficult to understand—in a sense, they are the opposite to 'positive symptoms' - voices and strong beliefs—but positive symptoms can lead to negative effects so they can involve a mixture of causes, including effects of the illness itself, side effects of medication and depression. They are described by the following technical terms—with a simpler explanation to help you understand them:

Affective flattening: the person may appear to have difficulty communicating emotion or expressing their feelings through facial expression. It may be biological in origin or caused by circumstances. It may be that the person is effectively 'in shock'. This may be related to past traumatic events e.g. bereavement, or it may be appropriate behavior for the circumstances in which they lived, e.g if shows of emotion are disapproved of in their family. It may be a direct reaction to abusive, unpleasant voices or thoughts and the 'frozen' expression, a 'front' to the world, an attempt to cope with seemingly overwhelming disturbance. Depression itself will present with affective flattening. Medication can also contribute. Side effects, e.g. stiffness and reduction in movements of face and body, can be caused by antipsychotic drugs, especially the older 'typical' drugs.

Alogia: This can be thought of as 'lack of thoughts' but may be difficulty communicating them. One reaction to criticism, real or anticipated, can be to 'shut up'. Anxiety and perception of pressure certainly can impede communication causing interruption, even stopping, of thoughts ('thought block').

Avolition: absence of drive and motivation is possibly the most disabling of negative symptoms. It is certainly one of the most frustrating. The person seems 'lazy', 'bone-idle' and 'never going to get anywhere in life' but perhaps a better expression is 'driven to a standstill'. Very often it emerges that lack of effort may now seem the problem but this has certainly not always been the case. People with a range of abilities and achievements may present with avolition. A drop-off in performance is common and will often follow failure to achieve expected results and then pressure and anxiety surrounding this. A vicious circle develops where the more they try, the less able they are to complete tasks successfully so the more frustrated and demoralised they become. Others around them may unintentionally contribute by encouragement which can itself seem to be pressure. Society may also increase pressures, e.g. to get a spouse, job and family. For many persons this is not an unreasonable long-term goal but a short-term nightmare (see ways of combating this over the page).

Anhedonia: This can be confused with depression but essentially involves a sense of emptiness and so is considered a negative rather than a primarily emotional symptom. It may be related to demoralisation, hopelessness, or feeling numbed by stress.

Attention deficit: there is good evidence for poor attention and concentration with mental health problems. Persons do worse on psychometric testing than normal controls. But preoccupation and distraction also occur because of hallucinations, especially when these are vivid and intrusive, but also other thoughts, either delusional, obsessional or simply very worrying or even, interesting to the person. If you think the police are coming to get you or the world is ending soon, it's quite likely that your mind will be preoccupied with that rather than therapy, assessment or even psychological testing. Overstimulation may also contribute and increase attentional deficit with the more the person tries to attend the more these thoughts about thoughts ('God, aren't I useless') may interfere.

Social withdrawal: Withdrawal may be an appropriate way to cope with overstimulation which has long been recognised as an issue in rehabilitation. Social overstimulation may be a particularly unpleasant source of stress.

What can help?

There is now good evidence from studies in the UK and Canada that cognitive therapy helps reduce negative as well as positive symptoms. It is used in addition to the usual treatments and can also help people understand why, for example, medication may be useful so that they are more prepared to take it - and discuss their needs with their doctor or mental health worker. Medication can help by reducing positive symptoms—voices, thought disorder and the adverse effects of strong beliefs– with beneficial effects on motivation and distress. It can also help with depression and some medications-Clozapine is the best example– seem to have a direct effect on negative symptoms themselves.

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton, UK
SO17 0YG

Email: dgk@soton.ac.uk

Further reading: Kingdon DG, Turkington D. *Cognitive Therapy of Schizophrenia.* Guilford Press, 2004.

UNDERSTANDING WHAT OTHERS THINK

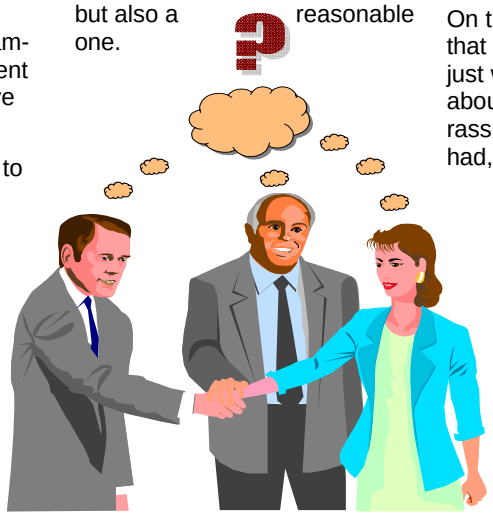
Thoughts can sometimes be quite confusing: sometimes this can lead to misunderstandings about the way people communicate or refer to each other. The following might be useful to you if you're feeling confused in this way

Can you read other people's thoughts or they read yours?

Over the years, many people have tried to work out whether it is possible for one person to read someone else's mind or to get them to think what the person themselves is thinking. In some ways it would be quite convenient not to have to say things and just think them to each other. There have been some instances where twins or brothers or sisters have believed that they have been aware when, for example, the other has had an accident or fallen ill, even when they have been a long way away.

People use the term 'telepathy' to describe this and quite a lot of people have some belief that some forms of telepathy occur. Scientists tried to test this in the 1950's and 1960's by using experiments. They got volunteers who would sit in one room and try to transmit a thought to someone in the next room. For example, they would look at a playing card drawn from a pack and the person in the other room would try to imagine which card they were holding. Or a set of cards with shapes or colours on them were used. The results of these experiments were not dramatic - in some cases, it seemed that the guesses were right more often than would be expected by chance but in most the results did not prove that telepathy was possible.

Of course, there are some people who believe that they have a particular ability to read other people's minds, for example, mediums and some spiritualists. If you ask them to read a particular person's mind, they won't usually do so, so there is not much evidence that they can do what they actually say. Some will be tricksters, others seem to genuinely believe what they say. It is as well to have an open mind but also a reasonable one.



You may feel yourself that you have this power. If you have, does it mean that you think you can read anybody's mind? If so, perhaps it would be worth checking this out with a close relative, friend, therapist, nurse or doctor. Thoughts can work in quite mysterious ways. They are essential to our existence but can sometimes be confusing. Have you ever had the feeling that you know exactly what someone else is thinking? It may be that something they did, which might have seemed like a sign to you, is the convincing factor.

Perhaps they said something that you are sure, they could only know if they read your thoughts. It may just be that you don't feel that you need anything to back up your belief, you just know it to be true.

On the other hand, you might be sure that someone else seems to know just what you have been thinking about. Sometimes it can be embarrassing because the thoughts you had, were violent or sexual. Maybe you looked up and saw them watching you and that convinced you.

Try to work out what evidence you have that they can actually know your thoughts. As we said earlier, there is not a lot of evidence to support the belief that people can read each other's thoughts. And there is no evidence that someone can broadcast their thoughts to people around them, even though you can sometimes be absolutely convinced that that is happening. Nor is there evidence that thoughts can be put into your mind or taken out by other people.

Talk with a health worker. See if you can test it out, if you're not convinced. When you are feeling very sensitive, these sorts of beliefs can develop and worry you. They are really an unfortunate diversion from dealing with practical and emotional problems you may have.

How can the TV, music or radio refer to you?

The TV, radio and music form an important part of most people's lives. They provide relaxation and information but sometimes the things they seem to be saying can seem to become just too personal.

It can seem like the TV presenter, for example, is saying things which must refer to you and you alone. He or she seems to know things about you that are personal and which you may have thought nobody else knew about. They may seem to refer to you by name. It can be very convincing and loud. Certain programmes seem particularly likely to cause problems; the News has been shown to be one, but documentaries and programmes like EastEnders or Frazier can also have the same effect.

Words in songs may seem to be directly related to what you are thinking in an uncanny way. It can be hard to believe that they can be intended for anyone but you alone.

When this happens, it can be worth just checking with someone who is with you - if anyone is with you - if they heard anything strange. Perhaps ask, for example, 'I thought I heard my name called, did you hear it?'

It is worth noting down what times of day and which programmes seem to be related to the problem, or note what is said about you, or what is being said as part of the song. If it is a song or you've got a video of the programme, going over it with a therapist, nurse, doctor or somebody you get on with, may help you work out what is happening.

Of course, sometimes people are referred to on TV, etc, when they've done something that is newsworthy but it is also possible that thoughts may have got muddled, things misheard or voices caused the problem. If voices might be the problem, you might want to look at 'Understanding voices' another leaflet in this series.

Having constant references to you can be very disconcerting, particularly when the references are critical or abusive as they often seem to be. When you have been under pressure or depressed, you can be very sensitive to things happening and this can be very confusing. It can mean you can be oversensitive. After all, why should people on the TV or radio refer to you? What could you possibly have done that could deserve that? It can help to talk these fears and concerns out with other people. Although it is best to talk about them to people who can help, they might just puzzle strangers. It is worth working out what may help.

And strangers?

When you are walking in the street or any public place, sometimes it can seem that people are talking about you or laughing at you. This can be very upsetting and worrying and even stop you going out. Because they look at you and then talk or laugh, it may seem reasonable to assume that they are referring to you. But they may just be thinking about other things—why is it that you think they are referring to you. If you were dressed or behaving strangely they might but if not, why? When you are feeling stressed, you can be very sensitive—over-sensitive—and sometimes these beliefs can develop out of that.

Coping with ideas of reference or thought broadcasting

- keep a diary to note when it happens (your therapist can give you one) :
- discuss your diary with your family, good friend or health worker
- unless it is too distressing or your health worker suggests it, don't stop watching TV, or going out, etc. This just limits your life.
- why should it/they refer to you? Talk to your health worker, family or good friends about any possible reasons
- medication may help, talk with a doctor about it

Research about thought broadcasting and reference.

The feeling that you are being referred to when that is not taking place is quite common. But when it becomes a fixed belief that doesn't seem to be based on good evidence, it can be distressing and seriously interfere with living. Cognitive behavioural therapy uses discussion of such beliefs to understand them better and perhaps put them into context so that things are not, inappropriately, taken personally. The information on this site has been carefully researched and results of randomised controlled studies in 'treatment-resistant schizophrenia' have recently been published showing the effectiveness of cognitive-behavioural techniques.

Further reading: Kingdon DG, Turkington D. *Cognitive Therapy of Schizophrenia.* Guilford Press, 2004.

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton, UK
SO17 0YG

Email: dgk@soton.ac.uk

UNDERSTANDING VOICES

The information in this leaflet has been useful to a number of people who are troubled by hearing voices. However some people hear voices and are quite happy with the experience – if you are one of these, the following may not be so relevant to you.

Hearing voices....

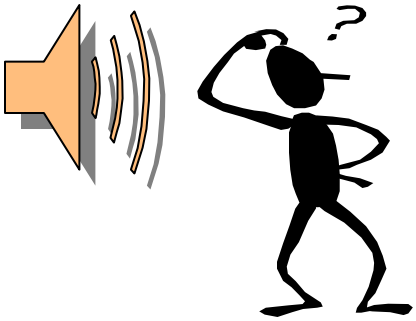
Hearing voices when nobody is around or at least when nobody seems to be saying the words you hear is quite common. Sometimes the things said seem to come from neighbours, TV, radio or people you pass in the street. Other times they can just seem to come out of the air.

They seem to be very real; they can be very loud. They may shout at you or sometimes just whisper. They can say all sorts of things. Sometimes the things said are not particularly upsetting but for most people they are worrying, threatening or abusive.

They may seem to be talking about you, even telling you what you are doing or thinking. This can be very puzzling, as it is difficult to understand how they can know such personal things. They can be particularly distressing when they are rude or abusive towards you. Sometimes they can swear or tell you to do awful things.

They can sound very convincing as if they have the power to make you do things, even when you don't want to do them.

It can be very difficult to work out where they are coming from. So it may be worth checking whether other people can hear the voices. If they can, they may be able to help you do something about them. Sometimes they can help you work out what or who is saying these things to you.



If they can't hear them, you need to work out why that might be the case. It may be that they aren't with you when the voices happen; see if you can tape-record whatever it is you are hearing. Maybe the voices seem to be directed at you alone - only you can hear them. It's worth trying to work out why that might be and talk about it with someone like a nurse, psychologist, spiritual adviser or doctor, who might be able to help. Sometimes it is caused by things happening to you: see the list of 'where voices come from'.

Voices may seem to be coming from behind you, through the walls even through loudspeakers. Or it can be very difficult to believe at times, voices that nobody else can hear are sometimes misinterpretations of other sounds or more usually thoughts sounding aloud. That doesn't mean that the voices sound like your own voice, they may be memories of someone else's voice or voices you don't recognise. It may be a man's voice or a woman's voice. Just like in dreams you can hear people speaking, so voices can be thoughts aloud. Memories of other people speaking or of a tune in your head are examples of sounds you can sometimes quite vividly recall.

It is important to understand that voices cannot make you do anything. Thinking that they can't control you, might make the voices feel worse initially. But if they are from your mind, it is up to you whether you act on what they say – in other words what you are thinking. But do get support if they seem overwhelming.

There are a variety of ways in which you can lessen the effect of voices or learn to cope with them better.

Where do voices come from?

Voices can occur in lots of different situations:

- when going off to sleep or waking up
- when stopped from going to sleep
- after a bereavement
- using drugs like speed – amphetamines- ecstasy, LSD and cocaine.
- when you have a very high temperature and with other physical illnesses
- severe states of deprivation, e.g. in a desert without water
- with illnesses like severe depression or schizophrenia
- when seriously deprived of stimulation, e.g. under conditions of sensory deprivation,
- In very stressful circumstances in hostage situations
- very stressful events like violent attacks, accidents or intimidation can sometimes imprint themselves on someone's mind as voices

Studies in the USA have shown that 4-5% of the population hears voices at any one time.

Supernatural or religious voices

The voice can seem like it comes from God or Satan, some supernatural source or even aliens of some sort. If it does you might want to talk over with someone like a therapist, psychologist, doctor, why you think that that is where it comes from. Has it said that to you itself? Well, is that reason to believe it? Would God say such unpleasant things? Satan (if you believe he exists) might but are you maybe jumping to conclusions that because the things said are so evil that it must be from an evil source - like the devil.
Such evil voices can occur as a result of being depressed or the effects of drugs like speed & cocaine. If you do have religious belief, you may find additional help through discussion with your spiritual adviser.

What can you do about voices?

The following are methods which have been useful at some time or other to people distressed by voices. Some may not be useful to you, but others may..

- **switch on the radio**
- **listen to music (maybe use headphones)**
- **have a warm bath**
- **talk to a friend**
- **go for a walk**
- **read a newspaper or magazine**
- **make a cup of tea**
- **try some vigorous exercise**
- **just relax - use whatever method of unwinding that works for you**
- **keep a diary so that you can work out when the voices come on and what starts them off: then you might be able to work out ways of dealing with them**
- **some people talk about 'developing a relationship with their voices' which can help—asking them why they are saying what they say**
- **maybe talk with or better ask in your mind why they are distressing you—what right they have to invade your privacy**
- **if they say you are bad, see if you can discuss it with them—talking about your good points also**
- **some people have found it helpful to allocate a certain time in the day to listen to the voices and then get on with their life at other times.**
- **if they tell you to do something you don't want to do, question them—explain that you don't deserve to be told to do such things and you want to take control of your own life**
- **perhaps talk with a doctor about how medication might help with the voices**
- **talk with a nurse, doctor or psychologist about ways of understanding the voices and developing other coping methods**

Brain scans of people who hear voices have shown that when the voices are active, there is brain activity in the area that normally indicates that they are speaking. It does therefore seem that voices, at least in the people scanned is literally 'inner speech'.

Further information: Kingdon DG, Turkington D. *Cognitive Therapy of Schizophrenia.* Guilford Press, 2004.
Also in some countries, **Hearing Voices Groups** have been set up which can be a rich source of support & information.

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton, UK
SO17 0YG

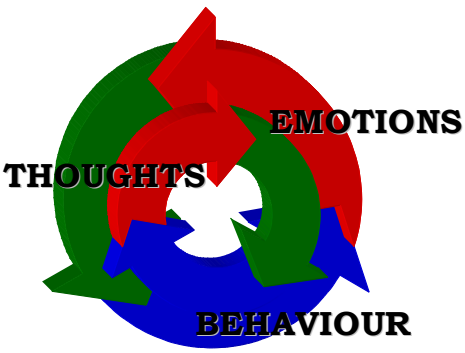
Email: dgk@soton.ac.uk

COGNITIVE THERAPY OF PSYCHOSIS

Many people find it very helpful to talk with somebody about the way they are feeling when they are depressed, anxious or confused. One way that has been shown to help with depression and anxiety is to talk about the thoughts that go along with the feelings. So when somebody's feeling low, it may be because they are thinking of their mother who has died or something else that has happened to them.

When somebody is confused and worried about things happening in their life, it may also be useful to try to work out what thoughts are relevant. So somebody may be upset because they are convinced that they are being followed or persecuted. It can then be worth trying to work out why they think that might be happening.

Cognitive therapy is a way of trying to identify and then understand these thoughts. They may be thoughts that on the surface seem reasonable but the fears have got out of proportion or things have been taken too personally. By weighing up the 'pros and cons' of a situation, it can be possible to look at it differently. It may be that there is an alternative to the conclusion that is causing such distress. Anxiety can cause all sorts of strange feelings like numbness or tingling, pain or breathing problems; these can sometimes be misinterpreted as, for example, electric shocks or physical interference by someone and these concerns may helpfully be discussed.



Sometimes there are beliefs which go back a long way which seem to shape how people view situations. For example, if they grew up to believe they were useless, when something goes wrong they may blame themselves, even if it wasn't their fault. Sometimes thoughts can sound like voices speaking out loud and, when this is happening, cognitive therapy can help people understand and cope with them better.

What is cognitive therapy?

Basically cognitive therapy involves talking to a nurse, doctor, psychologist or other trained person about the concerns and worries and trying to understand them better. This may mean:

- talking about how problems may have begun
- discussing how what was happening was interpreted
- understanding things that happen that seem strange
- finding out about the sorts of worries the person has

They may be hearing voices when nobody is about, or hear people referring to them as they walk past, or on the TV or radio. There are a variety of other things that can be helped by discussion, e.g. feelings that somebody or some organisation is persecuting the person or knows what they are thinking. On the other hand they may have beliefs about themselves that others don't seem to understand or accept, for example, that they are a particularly special person in some way.

For some people, it may help to

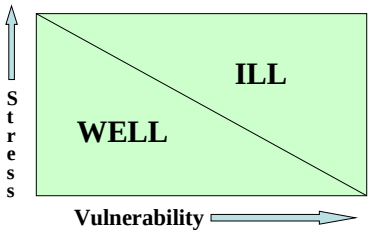
- keep a diary of these thoughts
- identify particular problems
- find out more about the beliefs, and how they might be affecting them
- see if anything particularly makes them better or worse

Coping with troublesome beliefs can be difficult when others don't believe the person. Talking about them with a mental health worker may help them do so.

Can cognitive therapy help with 'voices' and strong beliefs?

Sometimes people with psychosis can hear someone, or a number of people, speaking or shouting, but nobody else seems to hear them. 'Voices' like these can be very distressing: they may say abusive things about the person or tell them to do unpleasant things. Cognitive therapy can help them understand these voices - that they are usually the person's own thoughts or memories sounding as if they are aloud - and then work out what causes them and what to do about them. Understanding them is important in reducing the fear and anxiety caused and there are also a variety of coping techniques which can help. Strong beliefs can often be understood through reviewing the way stress and vulnerability interact.

Vulnerability-stress model



What about 'negative' symptoms?

When motivation seems very low and the person seems negative about everything, we describe this as having 'negative symptoms'. There may be a number of reasons for this, sometimes depression, sometimes voices and delusions which are not immediately apparent. Sometimes there is a fear of these symptoms coming back again and so all stress and stimulation is avoided. After an acute episode of illness, a period of convalescence and healing may be needed. Expectations need to be very realistic and sometimes this means a radical re-think; it may be an achievement to just answer a telephone call or watch a TV programme even in someone who was previously very capable. Small but readily achievable goals may be set to build confidence. The therapists may even advise that initially enduring a waiting period of just calm stability is appropriate, though not always easy to do. There is now good evidence that CBT helps patients by reducing pressure.

Doesn't it make voices and strong beliefs worse?

There is still a common belief amongst many doctors and nurses that talking about voices and strong beliefs makes them worse by focusing attention on them. Some psychiatric text books have advised against such discussion but there seems no direct evidence to support this. It is clearly wrong to force someone to talk about something if it distresses them but allowing them to talk, as occurs in cognitive therapy, seems humane and can be positive. If the person does become distressed, the conversation can be interrupted and then continue later, if appropriate. Where the discussion becomes repetitive, it probably is sensible to 'agree to differ' - a skilled cognitive therapist will then use techniques to overcome such blocks.

Can you use cognitive therapy instead of medication?

All the studies which have shown cognitive therapy to be effective have used it in combination with medication - including using some studies in which clozapine and the newer drugs, like risperidone and olanzapine, have been used. Sometimes people will accept drugs but not cognitive therapy, and sometimes therapy but not drugs - but it seems that the combination is best.

So does it really work?

There is now good evidence from studies in the UK , Canada, Netherlands, Italy and Belgium that cognitive therapy helps reduce symptoms. It is used in addition to the usual treatments, can help people understand why, for example, medication is useful so that they are more prepared to take it and help them discuss their needs with their doctor or mental health worker.

How can I get cognitive therapy for my self or my relative?

Initially it is best to discuss this with your current mental health worker or psychiatrist. Because it is so new, there are still only a few trained therapists around the US and many other countries although it is now much more available as part of standard clinical practice in the UK. Therapists are being trained on 'THORN Psychosocial Interventions' and CBT for severe mental illness courses and it is, increasingly, part of basic professional training. Organisations exist in most countries providing information on therapist availability e.g. Academy of Cognitive Therapy (www.academyofct.org), Association for Advance ment of Behavior Therapy (www.aabt.org) & British Association forf Cognitive Psychotherapies (www.babcp.org).

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton, UK
SO17 0YG

Email: dgk@soton.ac.uk

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TWO CBT CASES

Case one: Chronic paranoid schizophrenia, residual symptoms

The patient is a 58 y/o married white male with a history of treatment resistant paranoid schizophrenia since age 28. He was in the Air force at the time of the onset of symptoms. He was an aide to a four star general. Since responding a year ago to a combination of abilify and clozapine, he has been able to resume social involvement with his family and church.

His main delusional and hallucinatory experience involves homosexuality. A voice tells him he is homosexual and suggests homosexual acts to him, and he sometimes smells the odor of men's bodies.

The main interpersonal problem is the confusion of hallucinations with actual communication. He left a church meeting when he thought his son had made very critical comments about him to the group. At another time, he argued with his son, and kicked him out of the house, and then argued with his wife, when he thought his son had made homosexual advances toward him.

Case two: New onset schizophrenia, with paranoid and disorganized symptoms

The pt is a 29 y/o never married white male who was recently brought to urgent care by police. He had done a series of bizarre behaviors. He first entered Lake Mendota fully clothed and sat down in the water, coming out when a passerby called to him. He then went to a nearby construction site, climbed the fence and stole the boots of a workman. As he climbed back over the fence, he fell and rolled into a ditch full of cold water. Someone called police who found him shivering and muddy. He was mildly hypothermic in the ER. He refused admission and was ED'ed.

He agreed to take medication and was put on risperidone oral and long acting injection. Probable cause was found. He later agreed to a settlement, but as the date for discharge approached he made threats against his resident and admitted to having guns in his car. Two semiautomatic pistols were found in his car. He is awaiting a final hearing.

His mother was alcoholic, his step-father a combat veteran of Viet Nam. His parents divorced when he was an infant, and his mother and step-father divorced when he was 13. He went to work that year in the evening at a convenience store. He attended high school. At age 15 he joined a gang on the south side of Chicago. He began using marijuana and crack cocaine intermittently. At age 18 he joined the military, but was immediately rejected when a tox screen came up positive. For three years he wrote letters to legislators and obtained support wherever he could to get into the service, and at age 21 he joined the Marines. He trained in the highly stressful SERE program. He completed his service and decided not to reup, since no one in his platoon did. He also

felt his commanding officer had been abusive toward him. His father told him he should not complain about the abuse, since he had never been in combat.

The patient dates the onset of symptoms and of difficulty generally in his life, to 9-11. Before 9-11, he says he was engaged, his parents were both working and doing well, and he had friends. Afterwards he experienced a change in personality, broke up with his girl friend, and his parents fell on hard times, both losing their jobs. He felt estranged from his fellow marines; he began to have a hard time concentrating and was often irritable. He often felt frightened when in stressful training situations, and he felt persecuted by his commanding officer.

In 2002 after discharge from the military, he got a job with the Transportation Security Administration as a supervisor in the O'Hare airport. He found the job very stressful. He developed intense headaches and worried he had brain cancer. He admits to acting recklessly. He would wave his weapons around, twirling them and brandishing them around passengers. He would do searches inappropriately. He made false allegations of weapons possession, and finally closed the airport briefly due to such an allegation. He was fired. He has had brief periods of employment since then as a security guard. He has lived off and on either with his father in Chicago or with his mother in Milton. PTA he had his own apartment in Milton.

He has had brief episodes of alcohol abuse. In June of 2005 he had his only prior admission to a psychiatric unit, at the Hines VA in Chicago. He stayed for two weeks and was on aripiprazole (Abilify) with little response, and he did not continue medication after discharge.

His thought processes are characterized by multiple delusions, neologisms and odd expressions, and loose associations. He has no hallucinations. He has frequent ideas of reference. He has grandiose ideas. He is frequently guarded, but can also be amiable and talkative. His mood is generally anxious, sometimes angry and hostile, tense and threatening; but sometimes he is bright and relaxed. Generally his affect is blunted. He is isolative. He sometimes stares in a distracted way, or leers. His self care is good, meticulous and correct in a military style.

He tends to monopolize the conversation once he starts to describe his delusional thinking. He claims he is an Olympic athlete, able to survive in the water, but adds that he is a "marine social swimmer." He thought the water would purge certain ions that he associates with lower social class. He stole the boots because he wanted to disguise his high social status. He claims "sanctity" about his academic pursuits, his daily writing of journals and his aspirations to get three masters degrees. He claims he is "credentialed" still as a homeland security agent, and is "on consignment" to the government to root out the mafia. He claims the "Presbyterian mafia" is operating in northern Illinois in a garbage dump, but he expects to find the materials there to make "a homo-heliocentric telepathic device" and a time machine that he will use to save the world, and thus he would be recognized as the messiah.

His speech is not pressured, his sleep is good, and he has no hyperactivity. He has shown gradual but limited improvement after three weeks on Risperdal Consta, and is beginning to accept engagement in therapeutic conversation.

MAKING SENSE

Predisposing factors	Precipitating factors	Perpetuating factors	Protective factors

Current concerns

THOUGHTS	FEELINGS	ACTIONS

SOCIAL	PHYSICAL

UNDERLYING CONCERNS

WHAT'S THE PROBLEM?

When you are experiencing problems with stress—even if you think it is other people who have the problems, not yourself—it can be helpful to have a way of describing the problem. This leaflet aims to help you do so.

General terms

Depression—feeling low, unhappy, often with poor sleep and appetite, sometimes you can feel useless, hopeless, even guilty of doing things wrong (despite others saying you're not to blame). Thoughts of suicide or even harming others can develop and may take the form of voices speaking to you.

Anxiety—feeling stressed, worried, sometimes with physical feelings: heart racing, breathlessness, giddiness, tingling fingers, headaches, indigestion and feeling sick.

Obsessions—thoughts go round and round in your head, often they don't seem to be reasonable thoughts but they just keep on going however much you try to stop them.

'Voices'—when it sounds like someone is talking to you or about you but you can't work out exactly where the person who seems to be speaking is– they may seem to be in the room with you but you can't see them or outside it (the leaflet 'Understanding voices' may help explain).

Terms for symptoms like these are useful but often these symptoms form patterns which have been described as, for example, generalised anxiety disorder, manic-depression, schizophrenia but some of these terms have become stigmatised and are not very good descriptions—schizophrenia particularly has been used to describe a very broad group of problems and has attracted very negative attention over the years. New research using different ways of viewing these problems suggests that there are more appropriate and acceptable descriptions. Four groups have been identified:

Group 1: Sensitivity—*related to a particular sensitivity to stressful events or circumstances*

Group 2: Drug-related—*where the initial problems seem to have started after a bad experience with drugs like speed, cannabis, LSD or ecstasy*

Group 3: Anxiety-based—*where stress has built up in someone's life and then they believe that they have found the reason for it, but unfortunately others around them don't seem to agree.*

Group 4: Trauma-related—*'flashbacks' or 'voices' can arise which seem to relate to past traumatic events and can cause severe distress.*

The term **'psychosis'** is used in some circumstances where people hear 'voices' which they believe come from someone or something outside themselves, or hold strong beliefs which do not seem to be fully explained by the evidence that they produce in support of them. Often these beliefs and voices are understandable but not always easy to explain to others.

Sensitivity 'psychosis'

This group of problems usually involves:

- A slow, gradual onset
- A feeling of being under a lot of pressure but 'ground to a stand-still'
- Negative symptoms—difficulty motivating self, 'numbed' emotions, trouble communicating
- A range of problems especially when under stress which can include—paranoia, voices, unusual beliefs, jumbled thinking

Help focuses on improving tolerance to stress by initially reducing pressure and setting realistic goals (see leaflets 'Getting motivated' & 'Understanding how others think').

Drug-related 'psychosis'

This group

- Often starts with an episode of drug use—especially 'hallucinogenic drugs', speed (amphetamines), cocaine, ecstasy, LSD
- Can involve 'voices', 'flashbacks', strange feelings– which are very like those occurring with the first experience caused by drugs
- Continued drug use can bring on or worsen the symptoms—as can something which triggers a memory of it, e.g. seeing an ond drug using friend or TV programme about drug dealing.

Relating the experiences to the original drug use and then working directlyl with the symptoms can help (see leaflets 'Understanding voices' & 'Understanding how others think'

Anxiety 'psychosis'

This type of problem usually

- comes on after teenage, sometimes as late as 30's to 40's
- often it follows a period of stress from work, relationships, etc.
- a strong belief forms which seems to provide the explanation for what is happening to the person
- other people though, have problems agreeing with them and this can lead to conflict and distress

Help can come from understanding these beliefs (see leaflet 'Cognitive therapy for psychosis')

Traumatic 'psychosis'

Following a traumatic period, or event—although sometimes years later:

- distressing 'voices' start which say very unpleasant things about the person
- they may seem to be very powerful and may tell the person to do things, again usually unpleasant or harmful often to themselves
- the voice is often recognisable as someone from the past or at least to do with past events

Understanding the voices and learning ways to cope and be assertive with them can work with reducing distress. Feelings about the underlying traumatic events also need to be looked at – as often these make things worse.

Terms are useful but most important is what is done with them. There is evidence that what helps most is:

- Acceptance that treatment (medication & talking) can help
- Developing an understanding of the voices and beliefs that are important to you

Cognitive therapy is one way that may help (see 'Cognitive therapy for psychosis')

Further reading: Kingdon DG, Turkington D. *Treatment Manual for Cognitive Therapy of Schizophrenia*. Guilford Press, 2003.

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton, UK
SO17 0YG

Email: dgk@soton.ac.uk

UNDERSTANDING WHAT OTHERS THINK

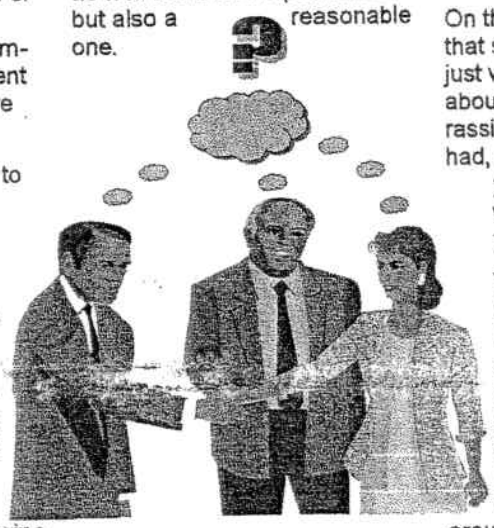
Thoughts can sometimes be quite confusing: sometimes this can lead to misunderstandings about the way people communicate or refer to each other. The following might be useful to you if you're feeling confused in this way

Can you read other people's thoughts or they read yours?

Over the years, many people have tried to work out whether it is possible for one person to read someone else's mind or to get them to think what the person themselves is thinking. In some ways it would be quite convenient not to have to say things and just think them to each other. There have been some instances where twins or brothers or sisters have believed that they have been aware when, for example, the other has had an accident or fallen ill, even when they have been a long way away.

People use the term 'telepathy' to describe this and quite a lot of people have some belief that some forms of telepathy occur. Scientists tried to test this in the 1950's and 1960's by using experiments. They got volunteers who would sit in one room and try to transmit a thought to someone in the next room. For example, they would look at a playing card drawn from a pack and the person in the other room would try to imagine which card they were holding. Or a set of cards with shapes or colours on them were used. The results of these experiments were not dramatic - in some cases, it seemed that the guesses were right more often than would be expected by chance but in most the results did not prove that telepathy was possible.

Of course, there are some people who believe that they have a particular ability to read other people's minds, for example, mediums and some spiritualists. If you ask them to read a particular person's mind, they won't usually do so, so there is not much evidence that they can do what they actually say. Some will be tricksters, others seem to genuinely believe what they say. It is as well to have an open mind but also a reasonable one.



You may feel yourself that you have this power. If you have, does it mean that you think you can read anybody's mind? If so, perhaps it would be worth checking this out with a close relative, friend, therapist, nurse or doctor. Thoughts can work in quite mysterious ways. They are essential to our existence but can sometimes be confusing. Have you ever had the feeling that you know exactly what someone else is thinking? It may be that something they did, which might have seemed like a sign to you, is the convincing factor.

Perhaps they said something that you are sure, they could only know if they read your thoughts. It may just be that you don't feel that you need anything to back up your belief, you just know it to be true.

On the other hand, you might be sure that someone else seems to know just what you have been thinking about. Sometimes it can be embarrassing because the thoughts you had, were violent or sexual. Maybe you looked up and saw them watching you and that convinced you.

Try to work out what evidence you have that they can actually know your thoughts. As we said earlier, there is not a lot of evidence to support the belief that people can read each other's thoughts. And there is no evidence that someone can broadcast their thoughts to people around them, even though you can sometimes be absolutely convinced that that is happening. Nor is there evidence that thoughts can be put into your mind or taken out by other people.

Talk with a health worker, see if you can test it out, if you're not convinced. When you are feeling very sensitive, these sorts of beliefs can develop and worry you. They are really an unfortunate diversion from dealing with practical and emotional problems you may have.

How can the TV, music or radio refer to you?

The TV, radio and music form an important part of most people's lives. They provide relaxation and information but sometimes the things they seem to be saying can seem to become just too personal.

It can seem like the TV presenter, for example, is saying things which must refer to you and you alone. He or she seems to know things about you that are personal and which you may have thought nobody else knew about. They may seem to refer to you by name. It can be very convincing and loud. Certain programmes seem particularly likely to cause problems; the News has been shown to be one, but the soaps like EastEnders can also have the same effect.

Words in songs may seem to be directly related to what you are thinking in an uncanny way. It can be hard to believe that they can be intended for anyone but you alone.

When this happens, it can be worth just checking with someone who is with you - if anyone is with you - if they heard anything strange. Perhaps ask, for example, 'I thought I heard my name called, did you hear it?'

It is worth noting down what times of day and which programmes seem to be related to the problem, or note what is said about you, or what is being said as part of the song. If it is a song or you've got a video of the programme, going over it with a therapist, nurse, doctor or somebody you get on with, may help you work out what is happening.

Of course, sometimes people are referred to on TV, etc, when they've done something that is newsworthy but it is also possible that thoughts may have got muddled, things misheard or voices caused the problem. If voices might be the problem, you might want to look at 'Understanding voices' another leaflet in this series.

Having constant references to you can be very disconcerting, particularly when the references are critical or abusive as they often seem to be. When you have been under pressure or depressed, you can be very sensitive to things happening and this can be very confusing. It can mean you can be oversensitive. After all, why should people on the TV or radio refer to you? What could you possibly have done that could deserve that? It can help to talk these fears and concerns out with other people. Although it is best to talk about them to people who can help, they might just puzzle strangers.

It is worth working out what may help:

And strangers?

When you are walking in the street or any public place, sometimes it can seem that people are talking about you or laughing at you. This can be very upsetting and worrying and even stop you going out. Because they look at you and then talk or laugh, it may seem reasonable to assume that they are referring to you. But they may just be thinking about other things—why is it that you think they are referring to you. If you were dressed or behaving strangely they might but if not, why? When you are feeling stressed, you can be very sensitive—over-sensitive—and sometimes these beliefs can develop out of that.

Coping with ideas of reference or thought broadcasting

- keep a diary to note when it happens (your therapist can give you one) :
- discuss your diary with your family, good friend or health worker
- unless it is too distressing or your health worker suggests it, don't stop watching TV, or going out, etc. This just limits your life.
- why should it/they refer to you? Talk to your health worker, family or good friends about any possible reasons
- medication may help, talk with a doctor about it

Research about thought broadcasting and reference.

The feeling that you are being referred to when that is not taking place is quite common. But when it becomes a fixed belief that doesn't seem to be based on good evidence, it can be distressing and seriously interfere with living. Cognitive behavioural therapy uses discussion of such beliefs to understand them better and perhaps put them into context so that things are not, inappropriately, taken personally. The information on this site has been carefully researched and results of randomised controlled studies in 'treatment-resistant schizophrenia' have recently been published showing the effectiveness of cognitive-behavioural techniques.

Further reading: Kingdon DG, Turkington D. *Treatment Manual for Cognitive Therapy of Schizophrenia.* Guilford Press, 2003.

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton, UK
SO17 0YG
Email: dgk@soton.ac.uk

UNDERSTANDING VOICES

The information in this leaflet has been useful to a number of people who are troubled by hearing voices. However Some people hear voices and are quite happy with the experience – if you are one of those, the following will not be particularly relevant to you.

Hearing voices....

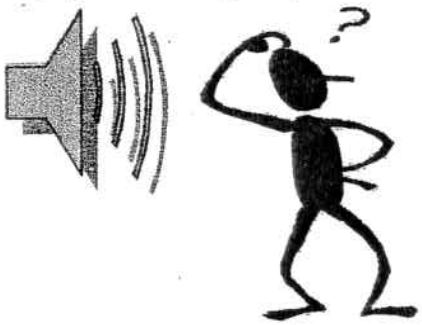
Hearing voices when nobody is around or at least when nobody seems to be saying the words you hear is quite a common thing to happen. Sometimes the things said seem to come from neighbours, TV, radio or people you pass in the street. Other times they can just seem to come out of the air.

They seem to seem very real; they can be very loud. They may shout at you or sometimes just whisper. They can say all sorts of things. Sometimes the things said are not particularly upsetting but for most people they are worrying, threatening or abusive.

They may seem to be talking about you, even telling you what you are doing or thinking. This can be very puzzling, as it is difficult to understand how they can know such personal things. They can be particularly distressing when they are rude or abusive towards you. Sometimes they can swear or tell you to do awful things.

They can sound very convincing as if they have the power to make you do things, even when you don't want to do them.

It can be very difficult to work out where they are coming from. So it may be worth checking whether other people can hear the voices. If they can, they may be able to help you do something about them. Sometimes they can work out what or who is saying these things to you.



If they can't hear them, you need to work out why that might be the case. It may be that they aren't with you when the voices happen; trying to tape-record them might be worth trying. Maybe the voices seem to be directed at you alone, only you can hear them. It's worth trying to work out why that might be and talk about it with anyone, like a nurse, psychologist, spiritual adviser or doctor, who might be able to help. Sometimes it is caused by things happening to you see the list of 'where voices come from'.

Voices may seem to be coming from behind you, through the walls even through loudspeakers. Although it can be very difficult to believe at times, voices that nobody else can hear are sometimes misinterpretations of other sounds or more usually thoughts sounding aloud. That doesn't mean that the voices sound like your own voice, they may be memories of someone else's voice or voices you don't recognise. It may be a man's voice or a woman's voice. Just like in dreams you can hear people speaking, so voices can be thoughts aloud. Memories of other people speaking or of a tune in your head are examples of sounds you can sometimes quite vividly recall.

It is important to understand that voices cannot make you do anything. Thinking that, might make them feel worse initially but if they are from your mind, it is up to you whether you act on what they say – in other words what you are thinking - but do get support if they seem overwhelming.

There are a variety of ways in which you can lessen the effect of voices or learn to cope with them better.

Where do voices come from?

Voices can occur in lots of different situations:

- when going off to sleep
- when stopped from going to sleep
- After a bereavement
- using drugs like speed – amphetamines- ecstasy, LSD and cocaine.
- when you have a very high temperature and with other physical illnesses
- severe states of deprivation, e.g. in a desert without water
- with illnesses like severe depression or schizophrenia
- when seriously deprived of stimulation, e.g. under conditions of sensory deprivation or in hostage situations
- very stressful events like violent attacks or intimidation can sometimes imprint themselves on someone's mind as voices

Studies in the USA have shown that 4-5% of the population hears voices at any one time.

What can you do about voices?

The following are methods which have been useful at some time or other to people distressed by voices. Some may not be useful to you, but others may..

Brain scans of people who hear voices have shown that when the voices are active, there is brain activity in the area that normally indicates that they are speaking. It does therefore seem that voices, at least in the people scanned is literally 'inner speech'.

- **switch on the radio**
- **listen to music (maybe use headphones)**
- **have a warm bath**
- **talk to a friend**
- **go for a walk**
- **read a newspaper or magazine**
- **make a cup of tea**
- **try some vigorous exercise**
- **just relax - use whatever method of unwinding that works for you**
- **keep a diary so that you can work out when the voices come on and what starts them off: then you might be able to work out ways of dealing with them**
- **some people talk about 'developing a relationship with their voices' which can help—asking them why they are saying what they say**
- **maybe talk with or better ask in your mind why they are distressing you—what right they have to invade your privacy**
- **if they say you are bad, see if you can discuss it with them—talking about your good points also**
- **some people have found it helpful to allocate a certain time in the day to listen to the voices and then get on with their life at other times.**
- **if they tell you to do something you don't want to do, question them—explain that you don't deserve to be told to do such things and you want to take control of your own life**
- **perhaps talk with a doctor about how medication might help with the voices**
- **talk with a nurse, doctor or psychologist about ways of developing other coping methods**

Supernatural or religious voices

The voice can seem like it comes from God or Satan, some supernatural source or even aliens of some sort. If it does you might want to talk over with someone like a therapist, psychologist, doctor, why you think that that is where it comes from. Has it said that to you itself? Well, is that reason to believe it? Would God say such unpleasant things? Satan (if you believe he exists) might but are you maybe jumping to conclusions that because the things said are so evil that it must be from an evil source - like the devil.
Such evil voices can occur as a result of being depressed or the effects of drugs like speed & cocaine. If you do have religious belief, you may find additional help through discussion with your spiritual adviser.

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton. UK
SO17 0YG

Email: dgk@soton.ac.uk

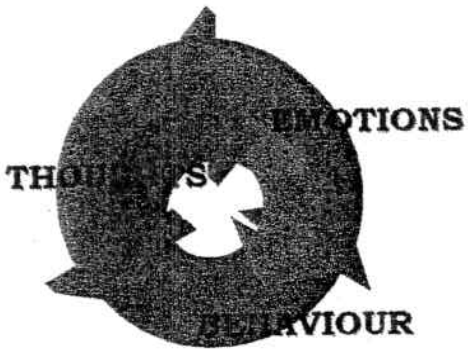
Further information: Kingdon DG, Turkington D. *Treatment Manual for Cognitive Therapy of Schizophrenia*. Guilford Press, 2003. Also in some countries, Hearing Voices Groups have been set up which can be a rich source of support & information.

COGNITIVE THERAPY OF PSYCHOSIS

Many people find it very helpful to talk with somebody about the way they are feeling when they are depressed, anxious or confused. One way that has been shown to help with depression and anxiety is to talk about the thoughts that go along with the feelings. So when somebody's feeling low, it may be because they are thinking of their mother who has died or something else that has happened to them.

When somebody is confused and worried about things happening in their life, it may also be useful to try to work out what thoughts are relevant. So somebody may be upset because they are convinced that they are being followed or persecuted. It can then be worth trying to work out why they think that might be happening.

Cognitive therapy is a way of trying to identify and then understand these thoughts. They may be thoughts that on the surfaceseem reasonable but the fears have got out of proportion or things have been taken too personally. By weighing up the 'pros and cons' of a situation, it can be possible to look at it differently. It may be that there is an alternative to the conclusion that is causing such distress. Anxiety can cause all sorts of strange feelings like numbness or tingling, pain or breathing problems; these can sometimes be misinterpreted as, for example, electric shocks or physical interference by someone and these concerns may helpfully be discussed.



Sometimes there are beliefs which go back a long way which seem to shape how people view situations. For example, if they grew up to believe they were useless, when something goes wrong they may blame themselves, even if it wasn't their fault. Sometimes thoughts can sound like voices speaking out loud and, when this is happening, cognitive therapy can help people understand and cope with them better.

What is cognitive therapy?

Basically cognitive therapy involves talking to a nurse, doctor, psychologist or other trained person about the concerns and worries and trying to understand them better. This may mean:

- talking about how problems may have begun
- discussing how what was happening was interpreted
- understanding things that happen that seem strange
- finding out about the sorts of worries the person has

They may be hearing voices when nobody is about, or hear people referring to them as they walk past, or on the TV or radio. There are a variety of other things that can be helped by discussion, e.g. feelings that somebody or some organisation is persecuting the person or knows what they are thinking. On the other hand they may have beliefs about themselves that others don't seem to understand or accept, for example, that they are a particularly special person in some way.

For some people, it may help to

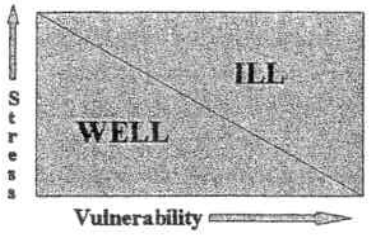
- keep a diary of these thoughts
- identify particular problems
- find out more about the beliefs, and how they might be affecting them
- see if anything particularly makes them better or worse

Coping with troublesome beliefs can be difficult when others don't believe the person. Talking about them with a mental health worker may help them do so.

Can cognitive therapy help with 'voices' and strong beliefs?

Sometimes people with psychosis can hear someone, or a number of people, speaking or shouting, but nobody else seems to hear them. 'Voices' like these can be very distressing: they may say abusive things about the person or tell them to do unpleasant things. Cognitive therapy can help them understand these voices - that they are usually the person's own thoughts or memories sounding as if they are aloud - and then work out what causes them and what to do about them. Understanding them is important in reducing the fear and anxiety caused and there are also a variety of coping techniques which can help. Strong beliefs can often be understood through reviewing the way stress and vulnerability interact.

Vulnerability-stress model



What about 'negative' symptoms?

When motivation seems very low and the person seems negative about everything, we describe this as having 'negative symptoms'. There may be a number of reasons for this, sometimes depression, sometimes voices and delusions which are not immediately apparent. Sometimes there is a fear of these symptoms coming back again and so all stress and stimulation is avoided. After an acute episode of illness, a period of convalescence and healing may be needed. Expectations need to be very realistic and sometimes this means a radical re-think; it may be an achievement to just answer a telephone call or watch a TV programme even in someone who was previously very capable. Small but readily achievable goals may be set to build confidence. The therapists may even advise that initially enduring a waiting period of just calm stability is appropriate, though not always easy to do. There is now good evidence that CBT helps patients by reducing pressure.

Doesn't it make voices and strong beliefs worse?

There is still a common belief amongst many doctors and nurses that talking about voices and strong beliefs makes them worse by focusing attention on them. Some psychiatric text books have advised against such discussion but there seems no direct evidence to support this. It is clearly wrong to force someone to talk about something if it distresses them but allowing them to talk, as occurs in cognitive therapy, seems humane and can be positive. If the person does become distressed, the conversation can be interrupted and then continue later, if appropriate. Where the discussion becomes repetitive, it probably is sensible to 'agree to differ' - a skilled cognitive therapist will then use techniques to overcome such blocks.

Can you use cognitive therapy instead of medication?

All the studies which have shown cognitive therapy to be effective have used it in combination with medication - including using some studies in which clozapine and the newer drugs like risperidone and olanzapine, have been used. Sometimes people will accept drugs but not cognitive therapy, and sometimes therapy but not drugs - but it seems that the combination is best.

So does it really work?

There is now good evidence from studies in the UK , Canada, Italy and Belgium that cognitive therapy helps reduce symptoms. It is used in addition to the usual treatments and can help people understand why, for example, medication is useful so that they are more prepared to take it - and discuss their needs with their doctor or mental health worker.

How can I get cognitive therapy for my self or my relative?

Initially it is best to discuss with your current mental health worker or psychiatrist. Because it is so new, there are still only a few trained therapists around the US and many other countries although it is now much more available as part of standard clinical practice in the UK. Therapists are being trained on 'THORN Psychosocial Interventions' and CBT for severe mental illness courses and increasingly as part of basic professional training. Organisations exist in most countries providing information on therapist availability e.g. Academy of Cognitive Therapy and British Association of Cognitive Psychotherapy.

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton, UK
SO17 0YG
Email: dgk@soton.ac.uk

Further reading:

Kingdon DG, Turkington D. *Treatment Manual for Cognitive Therapy of Schizophrenia.* Guilford Press, 2003.

GETTING MOTIVATED

Has your 'get up and go' got up and gone?

You can't push yourself - or anyone else - out of 'negative symptoms'

But there is a lot you can patiently do

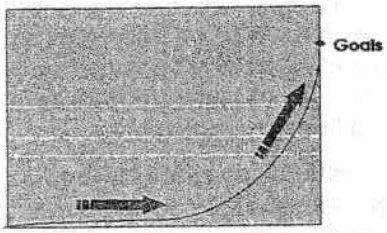
Problems to do with stress and mental health problems can seriously affect what we do and how we do it. All areas of life can be influenced—work and study can be difficult to pursue when you feel distracted, have poor concentration, lack the will to do things or just feel completely exhausted.

While this happens to everybody at some time in their life, when it becomes a persistent problem going on for weeks or months, simply hoping it will get better isn't good enough.

Relationships can be affected because you don't feel like talking opr just can't seem to get the words out. It may be difficult to feel close to others when you're distressed or just numbed.

Interests in hobbies, sports, TV, music, going out, friends and other people may be impaired and lead to a decrease in activities This can mean getting increasingly isolated and even if you did used to be reasonably sociable , you can get quite cut off and socially withdrawn.

Achieving expectations



Sometimes this can make life feel easier-less stressful– but in the long term can become dull, boring and depressing.

These symptoms are sometimes called 'negative' symptoms (see over page) and can be very disabling. It is very important initially to reduce feelings of stress and then start to set goals which are well within your capacity to do, with your mental health worker.

Setting reasonable goals

How much time do you need to rest and recover?.....months/years

Once feeling more relaxed, what would be your first step to getting back to 'normal'?

.....

.....(Don't complete until you feel ready to do so).

What are your longer-term goals, in 5-10 years time?

Work/study.....

Relationships.....

Hobbies/leisure.....

Living arrangements.....

What are negative symptoms?

The term 'negative' symptoms is used to describe a set of problems which are quite disabling and often difficult to understand—in a sense, they are the opposite to 'positive symptoms' - voices and strong beliefs—but positive symptoms can lead to the same effects so they can involve a mixture of causes, including effects of the illness itself, side effects of medication and depression. They are described by the following technical terms—with a simpler explanation to help you understand them:

Affective flattening: the person may appear to have difficulty communicating emotion or expressing their feelings through facial expression. It may be biological in origin or caused by circumstances. It may be that the person is effectively 'in shock'. This may be related to past traumatic events e.g. bereavement, or it may be appropriate behavior for the circumstances in which they lived, e.g if shows of emotion are disapproved of in their family. It may be a direct reaction to abusive, derogatory voices or thoughts and the 'frozen' expression, a 'front' to the world, an attempt to cope with seemingly overwhelming disturbance. Depression itself will present with affective flattening as a component of a broad depressive symptomatology. Medication can also contribute. Parkinsonian symptoms can be caused by antipsychotic drugs, especially the older 'typical' drugs.

Alogia: This can be thought of as 'lack of thoughts' but may be difficulty communicating them. One reaction to criticism, real or perceived, can be to 'shut up'. Anxiety and perception of pressure certainly can impede communication causing interruption, even stopping, of thoughts ('thought block').

Avolition: absence of drive and motivation is possibly the most disabling of negative symptoms. It is certainly one of the most frustrating. The person seems 'lazy', 'bone-idle' and 'never going to get anywhere in life' but perhaps a better expression is 'driven to a standstill'. Very often it emerges that lack of effort may now seem the problem but this has certainly not always been the case. People with a range of abilities and achievements may present with avolition. A drop-off in performance is common and in discussion will often follow failure to achieve expected results and then pressure and anxiety surrounding this. A vicious circle develops where the more they try, the less able they are to complete tasks successfully so the more frustrated and demoralised they become. Others around them may inadvertently contribute by encouragement which manifests itself as pressure. Society may also increase pressures, e.g. to get a spouse, job and family. For many persons this is not an unreasonable long-term goal but a short-term nightmare (see ways of combating this over the page).

Anhedonia: This can be confused with depression but essentially involves a sense of emptiness and so is considered a negative rather than a primarily emotional symptom. It may be related to demoralisation, hopelessness, or feeling numbed by stress.

Attention deficit: there is good evidence for poor attention and concentration with mental health problems. Persons do worse on psychometric testing than normal controls. But preoccupation and distraction also occur because of hallucinations, especially when these are vivid and intrusive, but also other thoughts, either delusional, obsessional or simply very worrying or even, interesting to the person. If you think the police are coming to get you or the world is ending soon, it's quite likely that your mind will be preoccupied with that rather than therapy, assessment or even psychometric testing. Overstimulation may also contribute and increase attentional deficit with the more the person tries to attend the more these thoughts about thoughts ('God, aren't I useless') may interfere.

Social withdrawal: Withdrawal may be an appropriate way to cope with overstimulation which has long been recognised as an issue in rehabilitation. Social overstimulation may be a particularly unpleasant source of stress.

What can help?

There is now good evidence from studies in the UK and Canada that cognitive therapy helps reduce negative as well as positive symptoms. It is used in addition to the usual treatments and can also help people understand why, for example, medication is useful so that they are more prepared to take it - and discuss their needs with their doctor or mental health worker. Medication can help by reducing positive symptoms—voices, thought disorder and the adverse effects of strong beliefs– with beneficial effects on motivation and distress. It can also help with depression and some medications-Clozapine is the best example– seem to have a direct effect on negative symptoms themselves.

Professor David Kingdon
Department of Psychiatry
Royal South Hants Hospital
Southampton, UK
SO17 0YG

Email: dgk@soton.ac.uk

Further reading: Kingdon DG, Turkington D. *Treatment Manual for Cognitive Therapy of Schizophrenia.* Guilford Press, 2003.

INTRODUCTION

"We can talk", a major American journal announced in 1997: "Schizophrenia is no longer a disorder in which psychological approaches have no place" (Fenton & McGlashan, 1997). Many people, including users of services, their carers and staff, are now trying to understand why people who are going through a troubled period in their life, feel or behave the way they do, and think about frightening, confusing, depressing or distressing matters. Irrespective of whether they are users or patients, carers, friends, nurses, social workers, doctors or psychologists, it is important that they have the capacity to control their emotions effectively. Some people seem able to do this intuitively, but most of us need help. We hope this book can provide some of that help by giving examples of how a variety of people from different backgrounds have spent time trying to understand and offer assistance in these circumstances.

People who have participated in the use of CBT—of one form or another—will be described. This will include not only users or patients who have experienced psychotic symptoms, but also those who have worked with them as carers or therapists. Both groups vary considerably in their experiences of symptoms and of using CBT with these symptoms. Participation and collaboration in therapy has been an essential basis for any progress that is seen. In their guided discovery of the experiences that have led to their meeting for therapeutic purposes, the patient and therapist will both have taken a lead.

Over the years, we have also been closely involved in training and supervising mental health workers and describe some of the positive and negative experiences involved. Similarly, the implementation of CBT in mental health services has progressed and is gradually becoming embedded in clinical services—but not uneventfully. Again this will be discussed and evidence for the effectiveness of CBT in psychosis will be reviewed briefly.

Finally, we would recommend that you read one or more of the available texts on CBT in psychosis, as they differ and complement each other in a

A Case Study Guide to Cognitive Behaviour Therapy of Psychosis. Edited by David Kingdon and Douglas Turkington.

variety of ways. Hazel Nelson's book (1997) is thorough and detailed in its description of therapy. David Fowler and colleagues (1995) have produced a book which is enlivened by case studies and broad clinical experience, while the text by Paul Chadwick and colleagues (1996) provides a very clear exposition of the use of the ABC framework in CBT. Our own text (Kingdon & Turkington, 1994) provides a theoretical basis for normalising symptoms and working systematically with them. However, in case such books are not readily available, we will present below a brief description of the key issues.

TECHNIQUES USED

Basis in cognitive behaviour therapy

The use of CBT in schizophrenia has been drawn from Beck's theory of emotional disorders (Beck, 1976). It has been founded on a tradition of evaluation, using experimental and research studies of defined therapeutic techniques. These techniques are problem-oriented and are aimed at changing errors or biases in cognitions (usually thoughts or images) involving the appraisal of situations and modifying assumptions (beliefs) about the self, the world and the future. The Cognitive Therapy Scale (Young & Beck, 1980) is used in research studies to ensure fidelity to the treatment model described by Beck and colleagues, but it is also a valuable tool in training. There have been adaptations to this for general use (e.g.Milne et al., 2001) and also for use in psychosis (Haddock et al., 2001). It describes the general therapeutic skills used in psychological treatment and the more specific conceptualisation, strategy and techniques used in cognitive therapy. The use of CBT in schizophrenia builds on these skills and techniques, although there are some differences in emphasis.

General skills

The general therapeutic skills described are those that are applicable to any psychological approach. They are aimed at enhancing what have been described as "non-specific factors" (Truax & Carkhoff, 1967)—the development of accurate empathy, non-possessive warmth, unconditional positive regard and non-judgementalism.

These skills also include agenda setting, which needs to be performed quite sensitively with patients with schizophrenia. Developing and agreeing an agenda may not be easy for them because of thought disorder, negativity or preoccupation with delusions and hallucinations, and this may involve

more prompting and suggesting, while retaining collaboration and eliciting feedback, than would occur when setting agendas for patients with different disorders. The agenda may even be implicit rather than explicit; for example, an initial session usually concentrates on engagement and assessment, so the agenda may simply be "to find out what problems you're having at the moment and begin to understand how they came about". Developing such understanding, displaying interpersonal effectiveness, and collaboration are further general skills. Pacing and the efficient use of time are important in engaging and retaining the patient in therapy. As silences can be anxiety-provoking and increase symptoms they are generally to be avoided but, on the other hand, patients need time to respond when their concentration is impaired and the pace of sessions needs to be judged carefully. The length of sessions may also need to be responsive to the mental states of patients. If they are becoming tired or particularly distressed, sessions may be wound down early. Occasionally if a complex delusional system or a particularly sensitive area is being explored, more time can be taken (within the constraints of the therapist's working schedule).

Cognitive therapy differs from other therapeutic interventions in its manner of conceptualisation and strategy, and the specific techniques, used. The concept of guided discovery is very important when working with patients with schizophrenia. Therapy is a journey of exploration into patients' beliefs, understanding them and finding out more about them, as far as possible, without preconceptions. That does not mean, of course, that the therapist will agree with the conclusions that the patients have reached, but he or she will understand how the conclusions developed, which will be explained further in discussion of the management of delusions and hallucinations. There is a focus on key cognitions; that is, "voices", delusional beliefs and behaviours—e.g. ways of coping with "voices" or avoidant behaviour in response to delusions of reference. The use of an ABC formulation can be valuable in clarifying the association between Antecedents, Beliefs and Consequences and assist patients to review their voices and beliefs constructively (see Chadwick, Birchwood & Trower, 1996).

A broad strategy for change is developed collaboratively with the patient from a formulation. The formulation will include discussion of predisposing factors (e.g. early childhood experiences), precipitating factors (life stresses, e.g. leaving home, adverse illicit drug experience) and perpetuating factors (e.g. continued unrealistic expectations and criticisms, or social circumstances). The development of key symptoms and beliefs will form part of this formulation.

The application of specific cognitive behaviour techniques will be described. Patients with schizophrenia may find difficulty in collaborating

with homework assignments and we tend to avoid the term. Instead we discuss "finding out" about something (e.g. satellite broadcasts: if the patients believe that these are influencing their thoughts). Where patients find difficulty with diaries, detailed recall of specific days can be used, e.g. "Do you remember what you did yesterday?", "What time did you get up?", "What time did the voices start?", "Where were you and what were you doing?", "What were they saying?".

Engagement

Developing a working alliance with patients with schizophrenia can be difficult where they have paranoid symptoms or have had difficulties with services in the past. They may not feel listened to and may expect you to dismiss their beliefs as 'mad'. However, when they find that the therapist is interested in their symptoms, their content, what they mean to them and how they have developed, engagement can be effectively secured. Studies in this area consistently find that, once they agree to participate in a study, less than 15% drop out. Engaging them in such studies or therapy can be difficult but the opportunity to state their case about their beliefs is frequently taken up with alacrity. This can be further improved by allowing them to lead a discussion, where they are able to do so, taking their concerns as primary—but prompting with known information when silence occurs—with the ultimate aim of having sessions that are relatively relaxing and comfortable. When it becomes hard work or distressing, it is generally better to pull back and use relaxation methods or casual conversation to conclude the session. Sometimes the patients will want to work through painful issues, but this needs to be carefully paced.

Tracing antecedents of symptoms

Understanding the circumstances in which delusional ideas or hallucinations began, even when they may be 30 years previously, can be invaluable in finding out why particular beliefs have arisen. For example, paranoid delusions and hallucinations may have occurred for the first time during a drug-induced psychosis ("bad trip") and need to be relabelled as originating with, although not currently caused by, that experience. Also, voices may relate to a specific traumatic event that is often accompanied by a depressive episode. A good conventional psychiatric assessment of the personal history can allow the pathological process to be charted using "guided discovery". This is particularly important for patients who have

been ill for a number of years, as the mists of time have often obscured the original precipitants. A direct approach—"When did you first think that. . . ." or "When were you last well or OK?"—may elicit the information needed, but may sometimes be less successful where distressing events are involved. Developing the story through personal history—beginning with birth and progressing to childhood, adolescence and the period preceding illness—may, by association, draw out the relevant precipitants where they exist. Accounts from relatives, clinical records or family doctor notes may be useful to prompt the patient. There remain a small number of patients who are unable to locate specific precipitants but can be overcome by the minor stresses of life.

Understanding patients' explanations

Patients use a variety of explanations for their symptoms, and these are elicited. Romme and Escher (1989) found that people who experienced auditory hallucinations described them as being caused by "trauma repressed", "impulses from unconscious speaking", "part of mind expansion", "a special gift or sensitivity", "expanded consciousness", "aliens", "astrological phenomena" and, more rarely, "a chemical imbalance or schizophrenia". To this can be added spiritual beliefs ("God or the Devil speaking") and technological explanations (satellites or radar, etc.).

To understand patients' explanations it may first be necessary to allow them to lead and explore the models of their mental health problems. It is often helpful to normalise, but this is not to minimise or be dismissive of their symptoms. A vulnerability/stress model is useful in explaining the illness, and is credible scientifically. Some patients have vulnerabilities that may have been inherited or caused by some physical effects on the brain, and the presence of stressful events (which might include chemical interaction, e.g. illicit drugs or viral illness) which may have precipitated the illness. For some people their vulnerability is very low, but the stress they have experienced has been high and overwhelming. Others seem very vulnerable to stress, and illness precipitates readily.

Alternative explanations for specific symptoms may be developed through discussion. Prompting the patients may be necessary, but the more the patients are able to provide their own alternative explanations the more likely they are to accept them. Anxiety symptoms are frequently misunderstood; e.g. the thought that 'my boss is controlling my mind' can arise from the giddiness associated with hyperventilation, or "I'm being shocked" from paraesthiae.

Delusions

Two factors appear important in delusion formation (Hemsley & Garety, 1986): prior expectation, i.e. "what you expect affects what you believe"; and the current relevant information provided by the environment, i.e. "the events occurring at the time and circumstances you find yourself in". Working with delusions involves establishing engagement, tracing the origins of the delusion, building a picture of the prodromal period, identifying *significant* life events and circumstances, identifying relevant perceptions (e.g. tingling, muzziness) and thoughts (e.g. suicidal, violent), and reviewing these negative thoughts and any dysfunctional assumptions. Patients are particularly prone to taking things personally, getting things out of context and jumping to conclusions.

The content of the delusion needs to be explored: the nature of the evidence that the patient has assembled *for* the delusion; and the evidence he or she can produce that seems to argue against the delusion. Alternatives are developed: "Are there any other possible explanations?"; "If someone said that to you, how would you respond?". The process continues by gentle prompting: "What about...?", "Do you think just possibly...?" Where delusions are resistant or if the discussion appears to be going round in circles, a technique described as inference chaining may be valuable. However, *if the patient is becoming agitated, distressed or hostile, discontinue* the session. Discussion with a cognitive therapist who is experienced in this area, if available, may allow the recommencement of therapy. Inference chaining can proceed through the factual implications of a belief, e.g. "If you have a transformer in your brain, doesn't it need electricity to work?" or emotional consequences, "OK, I do have some problems with this belief that you have... but if other people accept what you are saying, what difference would that make to you." This can then be followed through to specific concern, e.g. "I'd be respected", "By whom in particular?", "My family". These issues can then be worked with: "Although I may not be able to accept your belief" (e.g. that you are the Jesus Christ), "I may be able to help you to look at how you can gain the respect of your parents."

Hallucinations

Working with hallucinations involves initial assessment of the relevant dimensions, i.e. conviction, preoccupation, distress, content, frequency and pattern of occurrence. Any "voices" are discussed and differentiated from illusions and delusions of reference. Agreement will usually be reached that they resemble "someone speaking to you as I am doing now" (or perhaps

shouting or mumbling). The individuality of the perception is established: "Can anybody else hear what is said?... not parents, friends, etc.?" This is agreed although it may involve the person checking with others about whether they can be heard. Beliefs about the origin of voices are explored: "Why do you think they can't hear them?" Often the patient is unsure of his or her origin or produces delusional beliefs. Techniques for delusions (see above) can be used if appropriate. Possible explanations will then be explored: e.g. "it may be schizophrenia". Stressful situations in which voices can arise may usefully be described as they can help to normalise the experience, i.e. many people under certain forms of stress can hallucinate. This can be induced through sleep deprivation (Oswald, 1984), sensory deprivation states (Slade, 1984) and other stressful circumstances, such as bereavement, hostage situations (Grassian, 1983), PTSD and severe infections. In other words, 'voices can be stress related—because you hear them does not mean that you are a different sort of person from everybody else. When people are put under certain types of stress, e.g. sleep deprivation, they may also hallucinate.'

The aim is to raise the possibility that voices are internal—the person's own thoughts. The analogy with dreams and nightmares may help with this: 'a living nightmare'. Medication and coping strategies, e.g. listening to music, a warm bath, attending 'Hearing voices' groups (of other patients who suffer similarly), then become more relevant. Also, exploration of the content of voices can occur. Where this is abusive, violent or obscene, perhaps making commands, the voices are often related to previous traumatic events or depressive episodes, and specific work can then be efficacious. Voices may seem omnipotent (Chadwick & Birchwood, 1994) but: 'Just because a voice says something, however loudly and forcefully, does not mean it is true... or that you have to act upon it.'

Thought disorder

Disorder of the form of thought, however caused, interferes with communication, and techniques have been developed for clarifying verbal communication in these circumstances (Turkington & Kingdon, 1991). They involve allowing patients' speech to flow, then gently prompting them to focus down on specific themes as they emerge. Usually the themes selected are those which, on the surface, sound distressing—e.g. distressing events that may be mentioned. Neologisms and metaphorical speech are clarified by gentle questioning, and once a theme is selected the patients are drawn back to it each time they stray. The process is one that enables communication. It can be improved by audiotaping sessions and then reviewing them,

as pertinent themes may emerge from such reviews for discussion at the next session.

Negative symptoms

There is evidence that CBT improves negative symptoms (Sensky et al., 2000). Techniques involve eliciting specific positive symptoms, especially ideas of reference, thought broadcasting and hallucinations, which may emerge under stress. Patients may become essentially agoraphobic or socially phobic because of a fear of reactivating distressing positive or panic symptoms. They may also require a convalescence period after an acute episode, and a reduction in pressure and the postponement of some immediate expectations may be indicated. The protective function of stress avoidance, e.g. sleeping during the day and getting up in the quiet of the night, needs to be considered. Avoidance of stimulation may be a reasonable coping strategy while work with positive symptoms and stress management is pursued. Retaining hope is essential, so the development of realistic five-year plans may reduce the immediate pressures to "get better and get back to work/college". The aims may be the same, but the time scale is more realistic.

Clinical subgroups

Although a symptomatic approach is valuable in working with patients with psychoses, there are limitations to it in that, for example, hallucinations may present quite differently and cause different levels of distress in a person presenting with a range of psychotic symptoms than in someone for whom this is the predominant symptom relating to previous life events. This has increasingly led us to consider whether psychoses, including the schizophrenias, can be subgrouped (see Kingdon & Turkington, 1998). If valid and reliable groups can be developed, this could help with their management in determining responses to medication, psychological treatment, family work and rehabilitation measures. Such groups would also be expected to give indications of prognosis and assist substantially in research and training. Differentiation into bipolar disorder and schizophrenia has, arguably defined a spectrum rather than discrete entities. Previous descriptions of "the group of schizophrenias", as it was originally described (Bleuler, 1950), have included those appearing in International Classifications of Diseases, such as *simple, hebephrenia, catatonia, paranoid* or *schizoaffective*, and symptomatic classifications (e.g. Liddle et al., 1994), such as *positive, negative* or *disorganised*. These classifications have not proved useful

in clinical practice, yet there seems to be very general agreement that substantial differences between groups of patients exist. We have described four such groups (Kingdon & Turkington, 1998) that have proved helpful in planning treatment strategies, based on individual formulations. For convenience, these have been provisionally described as:

Gradual onset

- "sensitivity psychosis": individuals who develop psychosis gradually in adolescence with predominant negative symptoms;
- "trauma-related psychosis": individuals with traumatised backgrounds (usually from sexual abuse) with abusive hallucinations as predominant and most distressing symptoms.

Acute onset

- "anxiety psychosis": individuals who initially develop anxiety and depressive symptoms in response to a life event, are often socially isolated, who suddenly 'know' the reason for their distress and generally develop a single 'core' delusion elaborated into a delusional system with or without hallucinations;
- "drug-related psychosis": individuals whose initial presentation is with drug-precipitated psychosis followed by persisting psychotic symptoms, of the same nature and content, as the initial episode.

Management is focused on these specific symptoms, but the "core" delusion in "anxiety psychosis", for example, rarely responds to direct reasoning approaches although these help to establish a relationship with the patient, and often prompts investigation into underlying issues, e.g. isolation or poor self-esteem.

Medication issues

All the studies into CBT in schizophrenia have stressed the importance of medication. It is sometimes necessary to wait for medication to reduce acute psychotic symptoms before using CBT, especially with thought disorder, although the use of a CBT approach often allows negotiation on the use of medication or hospitalisation to occur. 'Compliance therapy', a brief form of CBT, has been specifically aimed at this. Where patients begin to understand that their voices are internal phenomena and that their beliefs just *might* be self-induced, they are more likely to take medication to alleviate these problems. Conversely, if medication has a positive effect, this reinforces work on helping them to accept voices as their own thoughts.

CONCLUSION

Cognitive behaviour therapy is a major advance in treating schizophrenia. In combination with medication, it offers effective interventions for a range of positive and negative symptoms and is very acceptable to most patients and carers. The techniques involved build on basic training for cognitive therapists and psychologists, and also case managers, nurses and psychiatrists, who are experienced in working with patients with schizophrenia. Manuals are available to assist with the development of skills. In some areas, training courses for mental health workers have been developed but there are currently far too few trained personnel; however, this situation may change with the emerging evidence of effectiveness and increased training opportunities (see later chapters).

CASES: SUBGROUPS AND PROMINENT SYMPTOMS

Cases	Subgroups				Prominent symptoms									
	PTSP[1]	Drug-related	Anxiety psychosis	Sensitivity psychosis	Hallucinations —abusive	Hallucinations —other	Paranoia	Thought disorder	Other delusions	Negative symptoms	Depression	Anger	Anxiety	Suicidality
1 John			*				**		*			*		
2 Janet				*	*		*		*	*	*	*	*	
3 Pat	*				**	*	*			*	*			
4 Helena	*				**					*	**		*	*
5 Kathy				*		** visions	*	*		*	*			
6 Nicky	*				**		*			*	**			*
7 Damien		*					*	**	*	*	*	*		
8 Sarah	*				**		*				*		*	*
9 Carole	*				**				*		*			*
10 Mary			*				**					*	*	
11 Karen			*				**		*				*	
12 Jane				*	*		**			**	*		*	
13 Malcolm				*		*	**		*		*			*
14 Colin			*				**				*		*	

* Present

** Prominent symptom

[1] 'Post-traumatic stress psychosis'

MAKING SENSE

Predisposing factors	Precipitating factors	Perpetuating factors	Protective factors

Current concerns

THOUGHTS	FEELINGS	ACTIONS

SOCIAL	PHYSICAL

UNDERLYING CONCERNS